Please check below all that apply, along with a list of all medications you are currently taking.

MEDICAL HISTORY

- □ Heart Trouble
- □ COPD
- □ Osteoporosis
- □ High Blood Pressure
- □ Stroke
- □ Blood Thinners
- □ Bleeding Problem
- □ AIDS/HIV
- □ Hepatitis
- □ Cancer
- □ Rheumatic Fever
- □ Diabetes
- □ Liver Disease
- □ Epilepsy
- □ Asthma
- □ Strep Throat
- □ Pneumonia
- □ Arthritis
- □ Tuberculosis
- □ Venereal Disease
- □ Thyroid Disease
- □ Fainting Spells
- □ X-Ray Therapy
- □ Sinus Trouble
- □ Kidney Disease
- □ Severe Headaches
- □ Stomach/Intestinal Problems
- □ Circulatory Problems
- □ Blood Disease (Sickle cell, etc)
- □ Eye, ear, nose, throat trouble

MEDICATION LIST:

_____
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_____

Are you allergic or sensitive to anything? □ **YES** □ **NO**
(Drugs, dental anesthetics, penicillin, latex, jewelry, etc.)
- If yes, please list: _____

Are you now under the care of a physician? □ **YES** □ **NO**
-If yes, please list why: _____

Have you had any joint replacement surgery? □ **YES** □ **NO**
-If yes, please list: _____

Have you had any heart valve replacement surgery? □ **YES** □ **NO**
-If yes, please list: _____

Are you taking any medications for osteoporosis? □ **YES** □ **NO**
(Fosamax, Actonel, Boniva, Reclast, Prolia, Zometa, Forteo, Atelvia, Binosto, Aredia, Didronel, Evista, Denosomab, Alendronic Acid, etc.)

Are you taking any blood thinning medications? □ **YES** □ **NO**
(Xarelto, Eliquis, Coumadin, Plavix, Aggrenox, Effient, Pradaxa, Zontivity, Savaysa, Warfarin, Persantine, Ticlopidine, Brilinta, Agrylin, Durlaza, Pletal, Asprin, etc.)

Have you been hospitalized in the past 2 years? □ **YES** □ **NO**

Do your ankles often swell? □ **YES** □ **NO**

Do you get out of breath easily? □ **YES** □ **NO**

Do you smoke? □ **YES** □ **NO**
If yes, how many years? _____ How many packs per day: _____

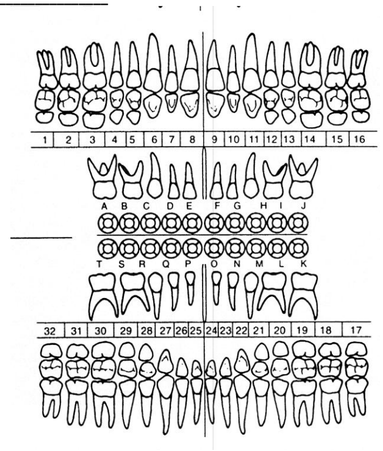
Do you use chewless tobacco? □ **YES** □ **NO**

Females Only: Are you pregnant? □ **YES** □ **NO**

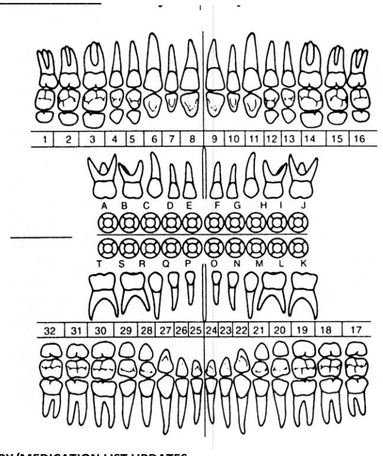
Please list any other medical condition(s) you feel I should be aware of:

_____
_____
_____

DATE: _____



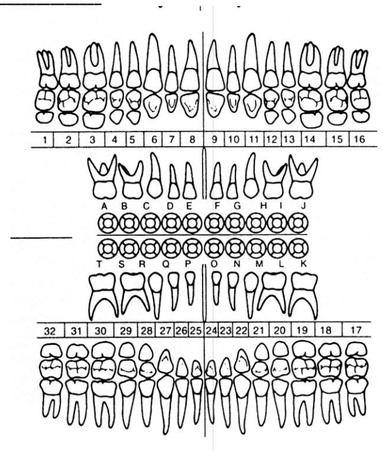
DATE: _____



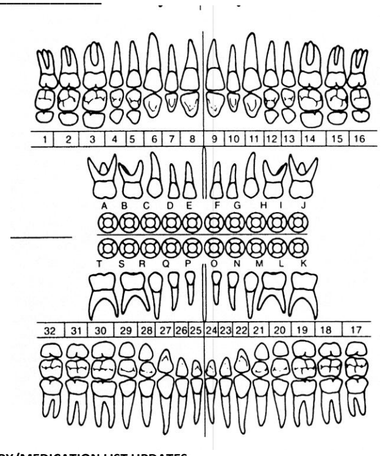
MEDICAL HISTORY/MEDICATION LIST UPDATES:

Date	Updates	Initials

DATE: _____



DATE: _____



MEDICAL HISTORY/MEDICATION LIST UPDATES:

Date	Updates	Initials

Philip C. Wilkins, D.M.D.
Reid P. Warren, D.M.D.
124 N. Congress Street
Winnsboro, SC 29180
Phone: (803) 635-6162

TO ASSIST US IN SERVING YOU, PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL FORM. THE INFORMATION ON THIS FORM IS NECESSARY FOR OUR RECORDS. PLEASE COMPLETE ALL PARTS.

PATIENT INFORMATION

_____
LAST FIRST MIDDLE

_____
STREET CITY STATE ZIP CODE

_____
HOME PHONE CELL PHONE OTHER(WORK)

DOB: _____ SSN_____ SEX: □ MALE □ FEMALE

MARITAL STATUS_____ OCCUPATION_____

EMAIL_____

PERMIT FOR TREATMENT

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable including the use of local anesthetic, nitrous oxide, and/or oral sedatives (additional release forms may be required) as indicated. I will assume full responsibility for fees associated with those procedures. I, also, agree to allow photography of my teeth if deemed necessary.
I consent to have my medical information released from my physician upon request, as allowed by HIPPA regulations.

X_____
Patient Signature Date

X _____
Parent/Guardian Signature (If under 18 years old) Date

DENTAL INSURANCE

_____
Name of Insurance Employer

_____
Name of Policyholder ID Number Relationship to Subscriber

MEDICAL INFORMATION

PHYSICIAN NAME: _____

PHYSICIAN NUMBER/LOCATION: _____

SPECIALIST NAME/NUMBER: _____

GENERAL DENTAL HISTORY

How long has it been since your last dental visit? _____

Are you currently having discomfort? _____

What would you like for us to do? _____

How long ago were your last teeth removed? (If applicable) _____

Are you interested in implants? _____

Tooth #							
Shade							

DATE	TH	SERVICE RENDERED

DATE	TH	SERVICE RENDERED

DATE	TH	SERVICE RENDERED

DATE	TH	SERVICE RENDERED
		`
		END OF CHART – PLEASE START NEW CHART.